

BDDSO 147M 5/02

1. OVERSIGHT AGENCY OMRDD		MINOR OCCURRENCE	
2. LOCATION B DC	3. PROGRAM TYPE		
4. ADDRESS 888 Penniman Ave			
5. PHONE BK NY 11208			
PART A - TO BE COMPLETED BY STAFF DESIGNATED IN POLICY			
6. SUBJECT'S NAME (Last, First) Young Valarie		7. AGE 33	8. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		9. I.D. No. 6396	
10. ADAPTIVE BEHAVIOR DEFICITS (X All Which Apply) MODERATE 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> SEVERE 6 <input checked="" type="checkbox"/> Communications 7 <input checked="" type="checkbox"/> Independent Living 8 <input type="checkbox"/> Learning 9 <input type="checkbox"/> Mobility 10 <input type="checkbox"/> Self Direction		11. MEDICATION REGIMEN (X One Only) 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Antibiotic Only 3 <input type="checkbox"/> Psychotropic Only 4 <input type="checkbox"/> Antiepileptic Only 5 <input type="checkbox"/> Antibiotic-Psychotropic 6 <input type="checkbox"/> Antibiotic-Antiepileptic 7 <input type="checkbox"/> Psychotropic-Antiepileptic 8 <input type="checkbox"/> Psychotropic-Antiepileptic-Antibiotic 9 <input checked="" type="checkbox"/> Other	
12. DATE & TIME OCCURRENCE WAS 1 <input checked="" type="checkbox"/> Observed 2 <input type="checkbox"/> Found		13. Number of other consumers with DD present at time of incident 1 14. Number of Employees Present at time of incident 1	
15. CLASSIFICATION OF INCIDENT (X One) 1 <input type="checkbox"/> Injury-Observed 2 <input type="checkbox"/> Injury-Found 3 <input type="checkbox"/> Medication Error 4 <input type="checkbox"/> Physical Intervention 5 <input type="checkbox"/> Chemical Restraint 6 <input type="checkbox"/> Altercation between 2 consumers 7 <input type="checkbox"/> Bite 8 <input type="checkbox"/> LWOC 9 <input checked="" type="checkbox"/> Other (Specify in #21)		16. CAUSES OF INCIDENT (X All Which Apply) 1 <input type="checkbox"/> Action of Consumer (See #19) 2 <input type="checkbox"/> Physical Handicap 3 <input type="checkbox"/> Seizure/Fainting 4 <input type="checkbox"/> Fall 5 <input type="checkbox"/> Physical Intervention 6 <input type="checkbox"/> Actions of Other Consumers 7 <input type="checkbox"/> Actions of Employee 8 <input type="checkbox"/> Actions of Visitor 9 <input type="checkbox"/> Hazardous Conditions on Facility Property 10 <input type="checkbox"/> Faulty, Inadequate or Inappropriate Equipment 11 <input checked="" type="checkbox"/> Other (Specify in #21)	
17. LOCATION OF INCIDENT <input checked="" type="checkbox"/> Indoors <input type="checkbox"/> Outdoors		18. SPECIFIC LOCATION 1 <input checked="" type="checkbox"/> Living Room 2 <input type="checkbox"/> Bedroom 3 <input type="checkbox"/> Kitchen 4 <input type="checkbox"/> Bathroom 5 <input type="checkbox"/> Hallway 6 <input type="checkbox"/> Staircase 7 <input type="checkbox"/> Dining Room 8 <input type="checkbox"/> Program Room 9 <input type="checkbox"/> Recreation Area 10 <input type="checkbox"/> Off Facility Property 11 <input type="checkbox"/> Other (Specify in #21)	
19. ACTIONS OF SUBJECT OF REPORT (X One Only if Box #1 in Item 16 was marked) 1 <input type="checkbox"/> Self Abusive 2 <input type="checkbox"/> Assaultive 3 <input type="checkbox"/> Provocative 4 <input type="checkbox"/> Accidental 5 <input checked="" type="checkbox"/> Other Specify in #21		20. WHAT CORRECTIVE OR OTHER ACTIONS HAVE BEEN TAKEN? 1 <input type="checkbox"/> Medical Treatment 2 <input type="checkbox"/> Subject Relocated 3 <input type="checkbox"/> Staff Relocated 4 <input type="checkbox"/> Maintenance Request 5 <input type="checkbox"/> Plan Modification 6 <input type="checkbox"/> Observation of Subject 7 <input type="checkbox"/> Supervision of Subject Other (Explain) YES	
21. DESCRIPTION OF INCIDENT: If report is completed by someone other than the one with first knowledge of situation, attach written report of that party and reports from any others involved. (1) Describe incident and include address if different from 2, 4 or 22 (2) Give names of witnesses and others involved (3) Specify first aid (if given) at 3rd when I came to work I found V.Y. in a wheel chair I tried to talk her out the chair but she cannot stand up alone, and have a hard time taking steps, and will slide to the floor she cannot walk.			
If take down was used: One Person _____ Two Persons _____ Face up _____ Other _____ (Describe) If time-out was used as an approved intervention, indicate Time In _____ Time Out _____			
22. SUBJECT'S PRESENT LOCATION (if different from residence)			
PRINT NAME OF PARTY COMPLETING THIS FORM Lillian Thomas		Title DA II	Signature <i>Lillian Thomas</i> Date 6-24-03
PRINT NAME OF PARTY COMPLETING REVIEW ANNA BENNETT		Title DA II	Signature <i>Anna Bennett</i> Date 6/24/03

YOUNG 8815